Advanced Health, LLC

2020 CCO 2.0 VBP Interview Questionnaire Response

By

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CCO 2.0 VBP INTERVIEW QUESTIONNAIRE RESPONSE

1 Describe how your CCO engages stakeholders, including providers, in developing, monitoring, or evaluating VBP models. If your approach has involved formal organizational structures such as committees or advisory groups, please describe them here.

Advanced Health's process for developing and evaluating value-based payments (VBP) begins informally with conversations between CCO staff and Providers we wish to establish VBP contracts with. A review of the Health Care Payment Learning & Action Network (HCPLAN) APM Framework and the Oregon Health Authority's (OHA) guidance documents usually leaves CCO staff with an understanding of the Provider's initial wishes and tolerance for risk.

The information is then discussed among an internal team consisting of CCO leadership, finance, and quality staff. Through selection of a payment mechanism and quality component(s), the internal team designs a VBP concept it believes will control costs, increase quality, and mitigate any unintended consequences or perverse incentives that may negatively impact Members, Providers, or other stakeholders.

A proposal is produced and presented to Advanced Health's Clinical Advisory Panel. The Clinical Advisory Panel was chosen as a forum for developing and evaluating VBP contracts to obtain perspectives more attuned to patient care and provider practices. The panel considers whether the proposed VBP contract is in the best interest of Members and Providers. The panel can recommend approval, changes, or dismissal of a VBP concept.

Advanced Health and Providers holding VBP contracts monitor VBP contracts using a suite of Tableau dashboards. In 2020, Advanced Health built an external-facing Tableau server through which Providers can monitor performance against any per-member-per-month (PMPM) spending or quality targets. The dashboards also show Providers any estimated bonus/penalty for quality or spending

performance and member risk stratification and member attribution, where applicable.

Advanced Health benefits from a long history of alternative payment model adoption. Prior to CCO 2.0, approximately half of Advanced Health's member services expenses were paid via HCPLAN category 4N contracts. The process of transitioning these contracts to HCPLAN 4A contracts can be as simple as tying payment to quality measure performance. Although the payment mechanisms for contracts like these were largely developed prior to CCO 2.0, they undergo the same evaluation and monitoring process.

2 Has your CCO taken steps in 2020 to modify existing VBP contracts in response to the COVID-19 outbreak?

Advanced Health's heavily capitated provider contracts were effective in partially insulating the majority of our providers from the financial impact of the COVID-19 outbreak. Approximately half of Advanced Health's member service expenses are paid via HCPLAN Category 4A or 4N contracts. We believe the COVID-19 outbreak strengthens the case for HCPLAN Category 4 contracts. Discussions are ongoing to transition HCPLAN Category 2C and 3B contracts to Category 4A. At this time, no existing VBP contracts have been modified.

5 Describe in detail any planned processes for mitigating adverse effects VBPs may have on health inequities or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally based communities; lesbian, gay, bisexual, transgender and queer [LGBTQ] people; persons with disabilities; people with limited English proficiency; immigrants or refugees; members with complex health care needs; and populations at the intersections of these groups).

Advanced Health recognizes that transitioning away from the fee-for-service model requires careful planning. It is critical that—in attempting to improve efficiency and quality of care—CCOs do not create perverse incentives or otherwise compromise Member health outcomes, especially for priority populations.

Advanced Health's VBPs will consist mostly of APM contracts such as risk sharing and PMPM-based capitation contracts. A common pitfall of APMs of these types is the potential for Providers to curtail appropriate care in order to avoid penalties, earn shared savings, or increase their margin against capitation. Unintended consequences are considered at every stage of Advanced Health's value-based payment process.

Advanced Health's mitigation process begins at VBP conception. Each VBP arrangement concept and any associated quality metrics are scrutinized by Advanced Health's leadership team. Each team member brings a unique perspective that can be used to search for unintended consequences. Team members

place themselves in the shoes of their contractor counterparts. They consider how they could behave under the contract to maximize reward and how those actions will impact Member care and outcomes, including their specific impact

on priority populations. Any potential perverse incentives or potential adverse effects are noted.

Advanced Health's Clinical Advisory Panel plays an important role in identifying potential adverse effects that Advanced Health's internal team fails to notice. As community Providers with strong relationships with patients, experience with patient care, and a mix of backgrounds in primary care, specialty care, behavioral health, and dental care, their perspectives can shed light on pitfalls CCO staff had not considered. Considering adverse effects and perverse incentives of VBP contracts is central to the panel's VBP review process.

Often potential unintended consequences can be guarded against. A common approach is to incorporate into the VBP contract a complementing measure that negates specific perverse incentives. For example, Advanced Health holds a capitated contract with the largest hospital in its service area. Without intervention, the contract could create a perverse incentive for the contracting hospital to reduce appropriate care in order to increase their margin against the PMPM payment. Including an incentive around NCQA's Plan All Cause Hospital Readmission Rate helps to negate this perverse incentive. Hospital readmission rate is a lagging indicator for appropriate care. If a Hospital cuts appropriate care by, for example, inappropriately reducing the length of inpatient stays, the cuts will likely have a negative impact on their readmission rate and will result in a negative financial outcome.

A similar process will be employed in the future when transitioning Advanced Health's current HCPLAN Category 4N primary care contracts to HCPLAN Category 4A contracts. We understand primary care Providers feel pressure to meet quality targets and some may see dismissing patients as an improvement strategy. Adding and appropriately weighting a countering measure like dismissal rate can neutralize this incentive.

In all Advanced Health's 2020 VBPs, improvement targets are set based on the Provider's past performance. This avoids penalizing Providers for caring for Members with complex health care needs or Members who would otherwise be more likely to negatively impact a Provider's performance.

Advanced Health believes adverse effects of VBPs are best mitigated by prevention. However, Advanced Health's suite of population health management tools allows for concurrent and retrospective review of patient outcomes. Advanced Health's leadership and quality staff regularly monitor performance on quality measures and negative changes in performance are investigated. If the root cause of declining

quality performance can be tied to a VBP contract, the contract is reviewed for changes or elimination.

6 Have your CCO's processes changed from what you previously planned? If so, how?

Advanced Health's process for developing, evaluating, and monitoring VBP contracts matches closely the process outlined in our CCO 2.0 application.

One notable *process* difference is the recruitment of Advanced Health's Clinical Advisory Panel to function as external oversight and review.

Advanced Health also deviated from the plan described in our application in selection of HCPLAN Categories for some contracts. Initially, it appeared we would transition all local rural hospitals to HCPLAN Category 3B or 4A contracts. However, one hospital remains fee-for-service and another preferred to start the transition at Category 2C.

7 What approaches are you taking to incorporate risk adjustment in the design of new VBP models, or in the refinement of existing VBP models?

Advanced Health plans to incorporate risk adjustment into VBP models and VBP reporting whenever possible and useful. Risk adjustment is an excellent way to pay Providers differentially or normalize Provider performance on metrics based on characteristics of their patient/Member population. Risk adjusting provider performance on metrics can also be an effective way to protect Members with complex health care needs from being targeted for dismissal; this mechanism is similar in outcome to basing Providers' quality improvement targets on past performance.

Advanced Health's 2020 VBPs include three hospital contracts and a substance use treatment contract of HCPLAN Category 2C, 3B, 4A, and 4A, respectively. Capitated payments and spending targets for the 3B and 4A contracts were negotiated independently based on historical payments. Improvement targets for associated quality measures were also set relative to each Provider's past performance. These factors led us to not incorporate risk adjustment into the payment model of these contracts. However, patient risk stratification data is a feature of the analytics tools provided to VBP contractors.

Several of Advanced Health's HCPLAN Category 4N contracts do feature risk adjustment. Nearly all Advanced Health's capitated primary care contracts feature risk-adjusted payments. We believe incorporating risk adjustment into VBP contracts is especially appropriate when there is an *assignment* relationship between Member and Provider and when Member characteristics are expected to influence cost of care. With the inclusion of a quality component, we expect these contracts will transition to HCPLAN Category 4A in 2021.

Advanced Health plans to use hospital readmission and emergency department utilization risk scores for futures VBPs. For example, we plan to incorporate the NCQA Ambulatory Care measure into primary care Provider contracts. Risk adjusting provider performance will allow us to more accurately assess Providers' relative performance, performance against a benchmark, and the impact of long term trends in Member risk on Provider scores.

8 Have you considered social factors in addition to medical complexity in your risk adjustment methodology?

Advanced has considered incorporating social factors in our risk adjustment methodology. This is a topic for which we would appreciate technical assistance. We understand factors outside of medical complexity are likely to influence outcomes and quality metric performance. We are interested in building these into our VBP contracts, but we have concerns about data quality and availability.

A 2017 trial[1] by National Quality Forum (NQF) found limited data quality and availability that roughly agreed with our experience:

FIGURE 2. SUMMARY OF DATA AVAILABILITY FOR SOCIAL RISK FACTOR INDICATORS

SOCIAL RISK FACTOR	DATA AVAILABILITY			
Indicator	1	2	3	4
SEP				
Income		■		
Education		■		
Dual Eligibility	■			
Wealth			■	
Race, Ethnicity, and Cultural Context				
Race and Ethnicity		■		
Language		■		
Nativity	■			
Acculturation				■
Gender				
Gender identity				■
Sexual orientation				■
Social Relationships				
Marital/partnership status		■		
Living alone			■	
Social Support			■	
Residential and Community context				
Neighborhood deprivation		■		
Urbanicity/Rurality	■			
Housing		■		
Other environmental measures				■

1. Available for use now
2. Available for use now for some outcomes, but research needed for improved, future use
3. Not sufficiently available now; research needed for improved, future use
4. Research needed to better understand relationship with health care outcomes and on how to best collect data

Source: National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment: Data.* Washington, DC: The National Academies Press; 2016.

[1] National Quality Forum. 2017. *Evaluation of the NQF Trial Period for Risk Adjustment for Social Risk Factors*. Retrieved from https://www.qualityforum.org/Publications/2017/07/Social_Risk_Trial_Final_Report.aspx

The outcome of the study was a recommendation for the use of a limited set of social factors on a limited set of quality measures. The 17 recommended measures have small denominators. For a small CCO like Advanced Health, credibly tracking performance over time may not be feasible.

We would be interested to learn about VBP models that have successfully incorporate social factors.

9 Describe the process your CCO has used in 2020 to address the requirement to implement per member per month (PMPM) payments to practices recognized as PCPCHs (for example, region or risk scores), including any key activities, timelines and stakeholder engagement.

Prior to CCO 2.0, Advanced Health paid PCPCHs on a PMPM basis, meeting the definition of the HCPLAN Category 4N model. The payments did not vary by PCPCH tier and they did not always increase each year.

To meet the CCO 2.0 PCPCH PMPM requirement in 2020, an infrastructure payment (HCPLAN Category 2A) was added to PCPCH contracts that varies by tier and will increase each year. The additional funds are meant to assist with the costs of attaining higher PCPCH tiers and to reward those who do. The new payment was communicated to PCPCHs during the contract revision process. All were agreeable to the new payment. All PCPCHs are asked to inform Advanced Health's finance team when their PCPCH tier changes. Once per quarter, PCPCH tier is verified using OHA's tracking tool. Foundational payment rates for PCPCHs are then updated for the next quarter.

This represents a deviation from the plan described in Advanced Health's CCO 2.0 application. At the time of applying, Advanced Health planned to pay PCPCHs a tier variable PMPM payment to support case management. Later, Advanced Health's case management team determined a tier variable PMPM payment did not best meet the goal of supporting clinic case management.

10 Has your CCO implemented new, or revised existing, payments to PCPCHs during 2020?

Payments to PCPCHs are updated on a quarterly basis, based on PCPCH tier. See Question 9 for more details.

11 Describe your CCO's plans for developing VBP arrangements specifically for behavioral health care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

Advanced Health currently contracts with county mental health organizations to provide outpatient services, crisis response teams, residential services, wraparound services, and other behavioral health services. These services are paid for under capitated contracts, meeting the definition of HCPLAN Category 4N. Advanced

Health will transition these contracts to Category 4A by introducing appropriate links to quality.

12 Describe your CCO's plans for developing VBP arrangements specifically for maternity care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

Advanced Health is reviewing the feasibility of bundled maternity payment models.

Advanced Health currently pays for the facility component of maternity charges on a capitated basis, through a HCPLAN Category 4A contract with our service area's largest hospital.

We will likely pilot a bundled payment for the professional component of labor and delivery charges similar to the model implemented by Pacific Business Group on Health, as described in HCPLAN's Maternity Whitepaper[2]. The narrow pilot will be a natural way to transition to a more inclusive maternity episode payment.

A more inclusive bundled payment will require significant work and investment. Advanced Health is currently transitioning to a new claims payment system. We are working with system vendor to ensure capabilities necessary to support bundled episode payments are built.

13 Describe your CCO's plans for developing VBP arrangements specifically for hospital care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

Advanced Health currently has three VBPs specifically for hospital care payments. Our largest DRG is paid on a PMPM basis (HCP LAN Category 4A). Two of the three rural hospitals in our service area are paid under Category 2C and 3B contracts, respectively. We plan to transition our rural hospitals to shared savings and risk or capitated models in 2021.

14 Have you taken steps in 2020 to develop any other new VBP models?

Advanced Health currently capitates dental and transportation Providers under HCPLAN Category 4N contracts. These may be transitioned to Category 4A contracts in 2021.

15 What TA can OHA provide that would support your CCO's achievement of CCO 2.0 VBP requirements?

Social Factors in Risk Adjustment: As mentioned in our answer to Question 8, Advanced Health requests technical assistance around incorporating social factors in risk adjustment.

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[2] HCP LAN. 2016. *Accelerating and Aligning Clinical Episode Payment Models: Maternity Care*. Retrieved from https://hcp-lan.org/workproducts/maternity-whitepaper-draft.pdf

Are there established models like CDPS+RX that model cost or other outcomes with social factor data?

Advanced Health relies on 834 files for most of our member data. The social factor data present in the data is limited and sometimes sparsely populated (e.g. language, ethnicity undisclosed or unknown). Collecting this data through our SDOH programs is possible but is likely to be similarly incomplete.

National Academies of Science, Engineering, and Medicine[3] produced a thorough report on accounting for social factors in Medicare payment. Many of the examples they describe do not use social factors to risk adjust prospective payments. Rather, social factors are used to "risk adjust" by partitioning Provider metric performance based on Member social factor status, bonusing for low disparities, or paying for improvement against a Provider's historical performance. Does OHA consider these examples of incorporating social factors in risk adjustment?

16 Aside from TA, what else could support your achievement of CCO 2.0 VBP requirements?

I appreciate the addition of the prescription drug payment arrangement examples to OHA's Value-Based Payment Technical Guide. We view the incorporation of pharmacy VBPs as a major hurdle for achieving the 70% VBP target by 2024. We would greatly appreciate the publishing of any success stories of CCOs that successfully incorporated a VBP into their pharmacy contracts.

On a related note, the technical guidance states "A payment from a CCO to a pharmacy benefit manager (PBM) in and of itself will not constitute a VBP payment." (p. 15) In this example, is the CCO payment to the PBM not considered a VBP simply because it does not include a quality component, or is OHA saying PBMs can not be considered Providers for the purpose of VBP contracting. If a CCO can find a way to incorporate a quality component into their payment with a PBM, can all spending on the PBM be considered a value-based payment?

17 Are there specific topics related to your CCO's VBP efforts that you would like to cover during the interview? If so, what topics?

Advanced Health pays for primary care services on a capitated basis. Although the Providers are paid for their work on quality incentive measures, I believe the contracts still fall into HCPLAN Category 4N.

Advanced Health pays primary care Providers for quality incentive services on a per-service basis. We feel this is the most effective way to incentivize providers to maximize their performance and improve patient quality of care. No matter how they are performing in terms of rate—whether they have far surpassed any

[3] National Academies of Sciences, Engineering, and Medicine. 2016. *Accounting for social risk factors in Medicare payment: Criteria, factors, and methods.* Washington, DC: The National Academies Press. doi: 10.17226/23513.

benchmark or improvement target, or if they would have no chance of meeting an improvement target—they have a positive incentive to perform more quality services. However, the OHA's Value-Based Payment Technical Guide[4] states "for the provider to qualify for the incentive under a payment arrangement, a process must be in place for the CCO to review the provider's performance against a pre-selected set of quality or performance measures and targets." (p. 11) Can our primary care arrangement be considered a Category 4A contract or must there be some improvement target-based quality component?

[4] Oregon Health Authority. *Value-Based Payment Technical Guide For Coordinated Care Organizations*. Retrieved from https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Technical-Guide.pdf